Senate

General Assembly

File No. 244

January Session, 2017

Substitute Senate Bill No. 807

Senate, March 27, 2017

The Committee on Insurance and Real Estate reported through SEN. LARSON of the 3rd Dist. and SEN. KELLY of the 21st Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT INCREASING THE MINIMUM NET WORTH OF AND SECURITY MAINTAINED BY PREFERRED PROVIDER NETWORKS, AND MAKING MINOR AND TECHNICAL CHANGES TO CERTAIN INSURANCE-RELATED STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (d) of section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims

process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for medical professionals or hospitals, which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by insurers for each specialty and the number of providers insured by specialty for each insurer.

(4) Not later than **[**March 15, 2007**]** June 30, 2018, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

Sec. 2. Section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) As used in this part and subsection (b) of section 20-138b:

(1) "Covered benefits" means health care services to which an enrollee is entitled under the terms of a managed care plan;

(2) "Enrollee" means an individual who is eligible to receive health care services through a preferred provider network;

(3) "Health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(4) "Managed care organization" means (A) a managed care organization, as defined in section 38a-478, (B) any other health insurer, or (C) a reinsurer with respect to health insurance;

(5) "Managed care plan" **[**means a managed care plan, as defined**]** has the same meaning as provided in section 38a-478;

(6) "Person" means an individual, agency, political subdivision, partnership, corporation, limited liability company, association or any other entity;

(7) "Preferred provider network" means a person **[**, which**]** that is not a managed care organization, but **[**which**]** that pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan;

(8) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services; and

(9) "Commissioner" means the Insurance Commissioner.

(b) **[**On and after May 1, 2004, no**]** No preferred provider network may enter into or renew a contractual relationship with a managed

care organization or conduct business in this state unless the preferred provider network is licensed by the commissioner. [On and after May 1, 2005, no preferred provider network may conduct business in this state unless it is licensed by the commissioner.] Any person seeking to obtain or renew a license shall submit an application to the commissioner, on such form as the commissioner may prescribe, and shall include the filing described in this subsection, except that a person seeking to renew a license may submit only the information necessary to update its previous filing. [Applications] Such license shall be issued or renewed annually on July first and applications shall be submitted by [March] May first of each year in order to qualify for the [May first] license issue or renewal date. The filing required from such preferred provider network shall include the following information: (1) The identity of the preferred provider network and any company or organization controlling the operation of the preferred provider network, including the name, business address, contact person, a description of the controlling company or organization and, where applicable, the following: (A) A certificate from the Secretary of the State regarding the preferred provider network's and the controlling company's or organization's good standing to do business in the state; (B) a copy of the preferred provider network's and the controlling company's or organization's financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such financial statement; (C) a list of the names, official positions and occupations of members of the preferred provider network's and the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the preferred provider network's and controlling company's or organization's activities with respect to the health care services network; (D) a list of the preferred provider network's and the controlling company's or organization's principal owners; (E) in the case of an out-of-state preferred provider network, controlling company or organization, a certificate that such

preferred provider network, company or organization is in good standing in its state of organization; (F) in the case of a Connecticut or out-of-state preferred provider network, controlling company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such preferred provider network, or controlling company or organization in this state or in any other state; and (G) the identity, address and current relationship of any related or predecessor controlling company or organization. For purposes of this subparagraph, "related" means that a substantial number of the board or policy-making body members, executive officers or principal owners of both companies are the same; (2) a general description of the preferred provider network and participation in the preferred provider network, including: (A) The geographical service area of and the names of the hospitals included in the preferred provider network; (B) the primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients; (C) a list of all entities on whose behalf the preferred provider network has contracts or agreements to provide health care services; (D) a table listing all major categories of health care services provided by the preferred provider network; (E) an approximate number of total enrollees served in all of the preferred provider network's contracts or agreements; (F) a list of subcontractors of the preferred provider network, not including individual participating providers, that assume financial risk from the preferred provider network and to what extent each subcontractor assumes financial risk; (G) a contingency plan describing how contracted health care services will be provided in the event of insolvency; and (H) any other information requested by the commissioner; and (3) the name and address of the person to whom applications may be made for participation.

(c) Any person developing a preferred provider network, or expanding a preferred provider network into a new county, pursuant to this section and subsection (b) of section 20-138b, shall publish a notice, in at least one newspaper having a substantial circulation in the service area in which the preferred provider network operates or will

operate, indicating such planned development or expansion. Such notice shall include the medical specialties included in the preferred provider network, the name and address of the person to whom applications may be made for participation and a time frame for making application. The preferred provider network shall provide the applicant with written acknowledgment of receipt of the application. Each complete application shall be considered by the preferred provider network in a timely manner.

(d) (1) Each preferred provider network shall file with the commissioner and make available upon request from a provider the general criteria for its selection or termination of providers. Disclosure shall not be required of criteria deemed by the preferred provider network to be of a proprietary or competitive nature that would hurt the preferred provider network's ability to compete or to manage health care services. For purposes of this section, criteria is of a proprietary or competitive nature if it has the tendency to cause providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and criteria is of a proprietary nature if revealing the criteria would cause the preferred provider network's competitors to obtain valuable business information.

(2) If a preferred provider network uses criteria that have not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a provider's practice under any specific program within the preferred provider network, the preferred provider network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that the provider's practice fails to meet.

(e) Each preferred provider network shall permit the Insurance Commissioner to inspect its books and records.

(f) Each preferred provider network shall permit the commissioner to examine, under oath, any officer or agent of the preferred provider

network or controlling company or organization with respect to the use of the funds of the preferred provider network, company or organization, and compliance with (1) the provisions of this part, and (2) the terms and conditions of its contracts to provide health care services.

(g) Each preferred provider network shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this part, and shall include such supporting documents as are necessary to explain the modification.

(h) Each preferred provider network shall maintain a minimum net worth of either (1) the greater of (A) **[**two hundred fifty thousand**]** five hundred thousand dollars, or (B) an amount equal to eight per cent of its annual expenditures as reported on its most recent financial statement completed and filed with the commissioner in accordance with sections 38a-53 and 38a-54, as applicable, or (2) another amount determined by the commissioner.

(i) Each preferred provider network shall maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for **[**two**]** four months determined on the basis of the **[**two**]** four months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner. Such amount may be credited against the preferred provider network's minimum net worth requirements set forth in subsection (h) of this section. The commissioner shall review such security amount and

calculation on a quarterly basis.

(j) Each preferred provider network shall pay the applicable license or renewal fee specified in section 38a-11. The commissioner shall use the amount of such fees solely for the purpose of regulating preferred provider networks.

(k) In no event, including, but not limited to, nonpayment by the managed care organization, insolvency of the managed care organization, or breach of contract between the managed care organization and the preferred provider network, shall a preferred provider network bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or an enrollee's designee, other than the managed care organization, for covered benefits provided, except that the preferred provider network may collect any copayments, deductibles or other out-of-pocket expenses that the enrollee is required to pay pursuant to the managed care plan.

(l) Each contract or agreement between a preferred provider network and a participating provider shall contain a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

(m) Each utilization review determination made by or on behalf of a preferred provider network shall be made in accordance with section 38a-591d.

(n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services. The Commissioner

of Social Services shall adopt regulations, in accordance with chapter 54, to establish criteria to certify any such federally qualified health center, including, but not limited to, minimum reserve fund requirements.

Sec. 3. Subdivision (8) of section 9-601 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(8) "Business entity" means the following, whether organized in or outside of this state: Stock corporations, banks, insurance companies, business associations, bankers associations, insurance associations, trade or professional associations which receive funds from membership dues and other sources, partnerships, joint ventures, private foundations, as defined in Section 509 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended; trusts or estates; corporations organized under sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, and chapters 594 to 597, inclusive; cooperatives, and any other association, organization or entity which is engaged in the operation of a business or profit-making activity; but does not include professional service corporations organized under chapter 594a and owned by a single individual, nonstock corporations which are not engaged in business or profit-making activity, organizations, as defined in subdivision (7) of this section, candidate committees, party committees and political committees as defined in this section. For purposes of this chapter, corporations which are component members of a controlled group of corporations, as those terms are defined in Section 1563 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, shall be deemed to be one corporation.

Sec. 4. Subsection (g) of section 10a-178 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July*

1, 2017):

(g) "Health care institution" means (1) any nonprofit, state-aided hospital or other health care institution, including The University of Connecticut Health Center, which is entitled, under the laws of the state, to receive assistance from the state by means of a grant made pursuant to a budgetary appropriation made by the General Assembly, (2) any other hospital or other health care institution which is licensed, or any nonprofit, nonstock corporation which shall receive financing or shall undertake to construct or acquire a project which is or will be eligible to be licensed, as an institution under the provisions of sections 19a-490 to 19a-503, inclusive, or any nonprofit, nonstock, nonsectarian facility which is exempt from taxation under the provisions of section 12-81 or 38a-188, as amended by this act, and which is a health care center under the provisions of sections 38a-175 to **[**38a-191**]** 38a-194, inclusive, as amended by this act, or (3) any nonprofit corporation wholly owned by two or more hospitals or other health care institutions which operates for and on behalf of such hospitals or other health care institutions a project, as defined in subsection (b) of this section, or is a nursing home;

Sec. 5. Subsection (a) of section 12-202a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Each health care center, as defined in section 38a-175, as amended by this act, that is governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall pay a tax to the Commissioner of Revenue Services for the calendar year commencing on January 1, 1995, and annually thereafter, at the rate of one and three-quarters per cent of the total net direct subscriber charges received by such health care center during each such calendar year on any new or renewal contract or policy approved by the Insurance Commissioner under section 38a-183, as amended by this act. Such payment shall be in addition to any other payment required under section 38a-48.

Sec. 6. Subparagraph (G) of subdivision (1) of subsection (a) of section 38a-71 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(G) Tangible components of health care delivery systems for health care centers governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, with the cost of these assets having a finite useful life being depreciated in full over periods provided by regulations adopted by the commissioner in accordance with the provisions of chapter 54;

Sec. 7. Subdivision (9) of section 38a-175 of the general statutes, as amended by section 20 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(9) "Health care center" means (A) any organization governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, and licensed or authorized by the commissioner pursuant to section 38a-41 or 38a-41a, for the purpose of carrying out the activities and purposes set forth in subsection (b) of section 38a-176, as amended by this act, at the expense of the health care center, including the providing of health care to members of the community, including subscribers to one or more plans under an agreement entitling such subscribers to health care in consideration of a basic advance or periodic charge and shall include a health maintenance organization, or (B) a line of business conducted by an organization that is formed pursuant to the laws of this state for the purposes of, but not limited to, carrying out the activities and purposes set forth in subsection (b) of section 38a-176, as amended by this act.

Sec. 8. Subdivision (2) of subsection (b) of section 38a-176 of the general statutes, as amended by section 21 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(2) For a health care center that provides medical and surgical services other than or in addition to dental services, the nature of the

activities to be conducted and the purposes to be carried out by such health care center, in addition to those set forth in subdivision (1) of this subsection, include, but are not limited to: (A) Entering into agreements with any governmental agency, or any provider for the training of personnel under the direction of persons licensed to practice any healing art; (B) establishing, operating and maintaining a medical service center, clinic or any such other facility as shall be necessary for the prevention, study, diagnosis and treatment of human ailments and injuries and to promote medical, surgical, dental and general health education, scientific education, research and learning; (C) marketing, enrolling and administering a health care plan; (D) contracting with insurers licensed in this state, including hospital service corporations and medical service corporations; (E) offering, in addition to health services, benefits covering out-of-area or emergency services; (F) providing health services not included in the health care plan on a fee-for-service basis; and (G) entering into contracts in furtherance of the purposes of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act.

Sec. 9. Section 38a-178 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Persons desiring to form a health care center may organize under the general law of the state governing corporations, partnerships, associations or trusts, subject to the following provisions: (1) The certificate of incorporation or other organizational document of each such organization shall have endorsed thereon or attached thereto the consent of the commissioner if the commissioner finds the same to be in accordance with the provisions of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act; and (2) the certificate or other document shall include a statement of the area in which the health care center will operate and the services to be rendered by such organization within this state and in other jurisdictions in which the health care center may be authorized to do business.

Sec. 10. Subsection (a) of section 38a-179 of the general statutes, as

amended by section 23 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) If a domestic health care center is organized as a nonprofit, nonstock corporation, the care, control and disposition of the property and funds of each such corporation and the general management of its affairs shall be vested in a board of directors. Each such corporation shall have the power to adopt bylaws for the governing of its affairs, which bylaws shall prescribe the number of directors, their term of office and the manner of their election, subject to the provisions of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act. The bylaws may be adopted and repealed or amended by the affirmative vote of two-thirds of all the directors at any meeting of the board of directors duly held upon at least ten days' notice, provided notice of such meeting shall specify the proposed action concerning the bylaws to be taken at such meeting. The bylaws of the corporation shall provide that the board of directors shall include representation from persons engaged in the healing arts and from persons who are eligible to receive health care from the corporation, subject to the following provisions: (1) One-quarter of the board of directors shall be persons engaged in the different fields in the healing arts at least two of whom shall be a physician and a dentist, except for a health care center that provides only dental services, one-quarter of the board of directors shall be persons engaged in the dental or related fields; and (2) one-quarter of the board of directors shall be subscribers who are eligible to receive health care from the health care center, but no such representative need be seated until the first annual meeting following the approval by the commissioner of the initial agreement or agreements to be offered by the corporation, and there shall be only one representative from any group covered by a group service agreement.

Sec. 11. Subsections (a) and (b) of section 38a-180 of the general statutes, as amended by section 24 of public act 16-213, are repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Any clinic established under sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, including a clinic that is a part of a medical service center or other facility, shall be subject to approval as a clinic by the Commissioner of Public Health pursuant to the standards established by said commissioner for approved clinics.

(b) Any person licensed to practice any of the healing arts or occupations employed by a health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall not be subject to reprimand or discipline because such person is an employee of the health care center or because such health care center may be engaged in rendering health care or related care through its own employees, except such person shall otherwise remain subject to reprimand or discipline by the state regulating board governing such profession or occupation as provided by law for such person's act or acts for unlawful, unprofessional or immoral conduct.

Sec. 12. Section 38a-181 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

A health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, may accept from governmental agencies, or from private agencies, corporations, associations, groups or individuals, payments, grants, loans or anything of value concerning all or part of the cost of its operation or agreements entered into between such health care center and its subscribers or other persons to be served by the health care center, or its employees, suppliers or contractors.

Sec. 13. Subsection (a) of section 38a-182 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) An agreement issued by a health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, may be issued for health care or the costs thereof to a subscriber, to a subscriber and spouse, to a subscriber and family, to a subscriber and

dependent or dependents related by blood, marriage or adoption or to a subscriber and ward. Such agreement or evidence of coverage document shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate.

Sec. 14. Subdivision (1) of subsection (a) of section 38a-183 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) (1) A health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract or policy. The commissioner may refuse such approval if the commissioner finds such amounts to be excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

Sec. 15. Section 38a-184 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Each health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, may expend sums, including sums in the capital reserve fund as provided in subsection (c) of section 38a-183, as amended by this act, for the following objects and purposes: (1) To purchase or lease real property for the purpose of construction of a medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program; (2) to purchase, lease or renovate all or part of an existing medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program or to lease a part of an existing hospital; (3) to amortize capital costs for the

purchase, construction or renovation of a medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program; (4) to purchase or lease equipment and such property as may be required in the delivery of health care and the transaction of business of the health care center; (5) to construct facilities, including a medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program, and to alter, improve or enlarge such facilities; (6) to make loans, including loans to a corporation under its control, for any of the objects and purposes heretofore prescribed; (7) to do any or all of the foregoing jointly or in association with another health care center, or jointly or in association with any other person, including any other corporation affiliated with a health care center.

Sec. 16. Section 38a-185 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

From any order or decision of the commissioner relating to any health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, an appeal may be taken by any person or organization aggrieved thereby in accordance with the provisions of section 4-183, except venue for such appeal shall be in the judicial district of New Britain. Any dispute which arises between a member of the community including subscribers eligible to receive health care from the health care center and each such center shall be referred, at the request of either party to such dispute, to the commissioner, who shall have the power to hear and decide the same, subject to appeal as herein provided.

Sec. 17. Section 38a-187 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

A health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, may purchase, lease, construct, renovate, operate and maintain medical facilities and equipment ancillary to such facilities and such other property as may be reasonably required for its principal office and for such purposes as

may be necessary in the transaction of the business of the health care center, and may otherwise invest in other securities permitted by the general statutes for the investment of trust funds, and in such other securities alone.

Sec. 18. Section 38a-188 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Each health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall be exempt from the provisions of the general statutes relating to insurance in the conduct of its operations under said sections and in such other activities as do constitute the business of insurance, unless expressly included therein, and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51, 38a-52, 38a-56, 38a-57, 38a-58a, 38a-129 to 38a-140, inclusive, as amended by this act, 38a-147 and 38a-815 to 38a-819, inclusive, provided a health care center shall not be deemed in violation of sections 38a-815 to 38a-819, inclusive, solely by virtue of such health care center selectively contracting with certain providers in one or more specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, provided a health care center organized as a nonprofit, nonstock corporation shall be exempt from sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health care center is operated as a line of business, the foregoing provisions shall, where possible, be applied only to that line of business and not to the organization as a whole.

(b) The commissioner may adopt regulations, in accordance with chapter 54, stating the circumstances under which the resources of a person that controls a health care center, or operates a health care center as a line of business will be considered in evaluating the financial condition of a health care center. Such regulations, if adopted,

shall require as a condition to the consideration of the resources of such person that controls a health care center, or operates a health care center as a line of business to provide satisfactory assurances to the commissioner that such person will assume the financial obligations of the health care center. During the period prior to the effective date of regulations issued under this section, the commissioner shall, upon request, consider the resources of a person that controls a health care center, or operates a health care center as a line of business, if the commissioner receives satisfactory assurances from such person that it will assume the financial obligations of the health care center and determines that such person meets such other requirements as the commissioner determines are necessary.

(c) A health care center organized as a nonprofit, nonstock corporation shall be exempt from the sales and use tax and all property of each such corporation shall be exempt from state, district and municipal taxes. Each corporation governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall be subject to the provisions of sections 38a-903 to 38a-961, inclusive. Nothing in this section shall be construed to override contractual and delivery system arrangements governing a health care center's provider relationships.

Sec. 19. Section 38a-189 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

No provision of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, nor any contract for health care by a health care center governed by said sections shall, in any way, affect the operation of the Workers' Compensation Act.

Sec. 20. Section 38a-190 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Any provisions of the statutes of this state regulating group medical, dental or other professions or occupations dealing with health care which is in conflict with sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall not apply to a health care

center governed by said sections.

Sec. 21. Section 38a-191 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Nothing in sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall preclude an insurance company authorized to conduct an accident and health insurance business in this state from performing marketing, enrollment, administration and other functions and from providing hospitalization insurance, including but not limited to emergency and out-of-area benefits, in conjunction with a plan providing health care to subscribers under existing provisions of the general statutes.

Sec. 22. Section 38a-192 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

The commissioner may adopt such regulations, in accordance with the provisions of chapter 54, as shall be necessary to carry out the provisions of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act.

Sec. 23. Subdivision (6) of subsection (a) of section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(6) (A) "Health benefit plan" **[**has the same meaning as provided in section 38a-591a;**]** means an insurance policy or contract, certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5) to (9), inclusive, (14) and (15) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics;

(viii) Other insurance coverage similar to the coverages specified in subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) (I) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, or (II) other similar, limited benefits that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, provided any benefits specified in subparagraphs (B)(ix)(I) and (B)(ix)(II) of this subdivision are provided under a separate insurance policy, certificate or contract and are not otherwise an integral part of a health benefit plan; or

(x) Coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (I) such coverage is provided under a separate insurance policy, certificate or contract, (II) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (III) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2017*	38a-395(d)
Sec. 2	*July 1, 2017*	38a-479aa
Sec. 3	*July 1, 2017*	9-601(8)
Sec. 4	*July 1, 2017*	10a-178(g)
Sec. 5	*July 1, 2017*	12-202a(a)
Sec. 6	*July 1, 2017*	38a-71(a)(1)(G)
Sec. 7	*July 1, 2017*	38a-175(9)
Sec. 8	*July 1, 2017*	38a-176(b)(2)
Sec. 9	*July 1, 2017*	38a-178
Sec. 10	*July 1, 2017*	38a-179(a)
Sec. 11	*July 1, 2017*	38a-180(a) and (b)
Sec. 12	*July 1, 2017*	38a-181
Sec. 13	*July 1, 2017*	38a-182(a)
Sec. 14	*July 1, 2017*	38a-183(a)(1)
Sec. 15	*July 1, 2017*	38a-184
Sec. 16	*July 1, 2017*	38a-185
Sec. 17	*July 1, 2017*	38a-187
Sec. 18	*July 1, 2017*	38a-188
Sec. 19	*July 1, 2017*	38a-189
Sec. 20	*July 1, 2017*	38a-190
Sec. 21	*July 1, 2017*	38a-191
Sec. 22	*July 1, 2017*	38a-192
Sec. 23	*from passage*	38a-472f(a)(6)

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

This bill increases the minimum net worth requirements for preferred provider networks and makes minor and technical changes to insurance-related statutes. This does not result in a fiscal impact to the state or municipalities since this bill only affects the private insurance industry.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sSB 807

AN ACT INCREASING THE MINIMUM NET WORTH OF AND SECURITY MAINTAINED BY PREFERRED PROVIDER NETWORKS, AND MAKING MINOR AND TECHNICAL CHANGES TO CERTAIN INSURANCE-RELATED STATUTES.

SUMMARY

This bill makes several unrelated changes in the insurance statutes. It:

1. increases the financial solvency requirements for a preferred provider network (PPN) by requiring that it maintain (a) a minimum net worth of $500,000, instead of $250,000, and (b) at least four months, instead of two months, worth of payments to participating providers (§ 2);

2. requires (a) PPNs to apply to be licensed by the insurance commissioner annually by May 1, instead of March 1, and (b) the commissioner to issue or renew PPN licenses annually by July 1, instead of May 1 (§ 2);

3. requires dental and vision carriers to abide by the law's network adequacy requirements (see BACKGROUND), which currently apply only to certain health carriers (§ 23);

4. delays the due date, from March 15 to June 30, of the commissioner's annual medical malpractice closed claims report to the Insurance and Real Estate Committee (§ 1); and

5. makes technical and conforming changes throughout the health care center (i.e., HMO) laws to specify that all HMOs are subject to all of the laws in Part I of Chapter 698a of the general statutes, including laws concerning insolvency (§§ 3 - 22).

EFFECTIVE DATE: July 1, 2017, except for the provision extending network adequacy requirements to dental and vision carriers (§ 23), which is effective upon passage.

PPN FINANCIAL SOLVENCY REQUIREMENTS

Preferred Provider Network

A PPN pays claims for the delivery of health care services; accepts financial risk for doing so; and establishes, operates, or maintains an arrangement or contract with providers relating to the services the providers render and the amounts they are paid. It does not include a managed care organization, workers' compensation preferred provider organization, independent practice association, physician hospital organization, clinical laboratory, or pharmacy benefits manager.

Minimum Net Worth

By law, a PPN conducting business in Connecticut must maintain a specified minimum net worth. Current law requires it to maintain either (1) the greater of $250,000 or 8% of its annual expenditures or (2) another amount the insurance commissioner determines. The bill increases the first condition to $500,000.

The law also requires a PPN to maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve, or other financial security acceptable to the commissioner for paying outstanding amounts owed to participating providers. Current law requires this to be the greater of (1) two months of payments owed to participating providers based on the two months in the past year with the greatest amounts owed, (2) the actual outstanding amount owed to participating providers, or (3) another amount the commissioner determines. The bill increases the first condition to four months of payments owed based on the four months in the past year with the greatest amounts owed.

BACKGROUND

Network Adequacy Requirements

PA 16-205 (§ 1) requires carriers to establish and maintain adequate provider networks to assure that all covered benefits are accessible to

covered individuals without unreasonable travel or delay. It requires that covered individuals have access to emergency services at all times.

The act also requires the insurance commissioner to review and determine the sufficiency of a carrier's provider network. Additionally, it requires a carrier to provide benefits at the in-network level of coverage when a nonparticipating provider performs covered services for a covered individual because a participating provider is not available in the network.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 20 Nay 0 (03/09/2017)